

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

CERTIFICATE OF DEATH

Reg. Dist. No. 167

1. PLACE OF DEATH:

County **Garrett**
 City or town **Rural Oakland**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **70 yrs.**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State **Maryland.** County **Garrett**
 City or town **Rural Oakland**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **9 MI. S W Oakland**
 (If rural, give LOCATION)

 2.(a) If veteran, name war -----

3. (a) FULL NAME

Lillia Ann Beckman

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Herman H. Beckman

7. Birth date of deceased (mo., day, yr.)

November 9, 1868

6. (c) If alive, give age ----- years

8. AGE:

Years

Months

Days

If less than one day

77**9****9**

hrs.

min.

9. Birthplace

Baltimore, Maryland.

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

Own Home

12. Name

Unknown

13. Birthplace

14. Maiden name

Rosanna Stahl

15. Birthplace

Garrett Co., Md.

16. Informant

Mrs. Benj. F. Knepp

Address

R. D. Oakland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof **Aug. 20, 1946**

(month) (day) (year)

Cemetery or crematory

Eglen, W. Va. Union Cem.

Location

Preston Co., W. Va.

18. Funeral director

Herbert C. Leighton

Address

Oakland, Maryland.

19. (Date rec'd by registrar)

8/2019. **46****Elmer C. Shaffer**

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 17** 19**46** **4:35P** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19**34** to **8/17** 19**46**and that I last saw her **er** alive on **August 17** 19**46**Immediate cause of death **urination +****dehydration**

DURATION

2 wksDue to **Pericarditis + vomiting** **2 wks**Due to **Hypertension, Cardiac asthma** **4 wks****+ acute congestive heart failure**

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations. **None**Autopsy results. **No**

Date of op. -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. ----- Date of -----

Where did injury occur? ----- (City or town) ----- (County) ----- (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE **Harold C. Miller M.D.**

M. D. or other

Address **Eglen, W. Va.** Date signed **8/19/46**

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

CERTIFICATE OF DEATH

08079

Reg. Dist. No. 171

1. PLACE OF DEATH: **Garrett**
 County.....
 City or town..... **Rural Near Bitteringer**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **35 Years**
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Md** County..... **Garrett**
 City or town..... **Rural Near Bitteringer**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Eliza Belle Broadwater

3. (b) Social Security Number
None

4. Sex **F** 5. Color or race **W** 6.(a) Single, married, widowed, or divorced **Widowed**
 6.(b) Name of husband or wife..... **Perry Broadwater**
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) **February 23- 1865**
 8. AGE: Years **81** Months **5** Days **25** If less than one day
 hrs. min.

9. Birthplace..... **Mill Run Garrett Co Md**
 (Town, county, and state)
 10. Usual occupation..... **House Work**
 11. Industry or business.....
 12. Name..... **Benjamin Green**
 13. Birthplace..... **Not Known**
 14. Maiden name..... **Mary Poland**
 15. Birthplace..... **Lonaconing Md**

16. Informant..... **Mrs Mary Brennen**
 Address..... **Bitteringer Md**
 17. **Burial** Date thereof..... **8-21-1946**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Bitteringer**
 Location..... **Bitteringer Md**
 18. Funeral director..... **Allen Wintersburg**
 Address..... **Grantsville Md**
 19. **Aug 19 1946** **J. B. Emory**
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **August 18 1946** 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Jan 46** to **Aug 18 1946**
 and that I last saw him alive on **Aug 17 1946**
 Immediate cause of death..... **Chronic Myocarditis** DURATION **2 yrs**
 Due to.....
 Due to.....
 Other conditions..... **Senility**
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE..... **N. D. Davis M.D.** M. D. or other
 Address..... **Grantsville Md** Date signed..... **Aug 19**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-0

CERTIFICATE OF DEATH

08080/164
Reg. Dist. No.

1. PLACE OF DEATH:

County Garrett
City or town accident
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
City or town Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)

2(e) IF VETERAN, NAME WAR

3. (a) FULL NAME

Lydia Tragle

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Perry Tragle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23-1866

8. AGE: Years 79 Months 9 Days 16 If less than one day hrs. min.

9. Birthplace Garrett Co. Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Bowser

13. Birthplace Garrett Co. Md

14. Maiden name Rebecca Musser

15. Birthplace Garrett co md.

16. Informant Sara R Tissue

Address Addison Pa

17. Burial Date thereof Aug 11-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Addison Cemetery

Location Addison Pa

18. Funeral director H. B. Rischebarger

Address Addison Pa

19. Aug 8 19 46 Emmach Spauldin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8th 1946, at 6 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1946, to Aug 7th 1946, and that I last saw her alive on August 7th 1946.

Immediate cause of death

Angina Pectoris

DURATION

1 year

Due to Arteriosclerosis

10 years

heart disease

Due to Generalized

arteriosclerosis.

Other conditions none

Major findings:

Of operations none

Of autopsy none

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of

Where did injury occur? none (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury none Injured at work?

23. SIGNATURE Milton Tepper, MD M. D. or other

Address Friendsville, Md Date signed Aug 8, 1946

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

08081

Reg. Dist. No. 161

1. PLACE OF DEATH:

County Garrett
 City or town Friendsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Barnes
 City or town Friendsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Percy Simon Friend

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Elna M. Friend
 6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Jan 19, 1882

8. AGE: Years 64 Months 6 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Md
 (Town, county, and state)

10. Usual occupation Justice of the Peace

11. Industry or business _____

12. Name Mrs H Friend

13. Birthplace Md

14. Maiden name Jane Friend

15. Birthplace Md

16. Informant Friendsville Md

Address Elna Friend

17. (Burial, cremation or other) Which? _____ Date thereof Aug 15, 1946

Cemetery or crematory Savage Addition

Location 10 Friendsville

18. Funeral director H H Surgen

Address Friendsville

19. Aug 15 19 46 Kathryn F. Friend Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 13, 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUGUST 13, 1946 to AUGUST 13, 1946

and that I last saw him alive on AUGUST 12, 1946

Immediate cause of death CORONARY OCCLUSION

Due to ARTERIOSCLEROSIS

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Milton Tepfer, M.D.

Address Friendsville, Md. Date signed Aug 13, 1946

(City or town) _____ (County) _____ (State) _____

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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SEP-4 1946

BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (b)

CERTIFICATE OF DEATH

08082

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
 City or town Oakland, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Murphy
Margaret Cecilia Kerins.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

8. (b) Name of husband or wife George T. Kerins.B. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) December 13th, 18928. AGE: Years Months Days If less than one day
53 8 15 hrs. min.9. Birthplace Oakland, Maryland.
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name Joseph Murphy.13. Birthplace Garrett County.14. Maiden name Mary Ellen O'Conner.15. Birthplace Ireland.18. Informant George T. Kerins.Address Oakland, Maryland.17. Burial Date thereof Aug. 30/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter's Cemetery.Location Oakland, Maryland.18. Funeral director Emory D. GoldenAddress Oakland, Md.19. 8/30/46 19 46 Julius A. Roman
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Oakland, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28th 1946 19 46 A.M. 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 17 Oct 19 45 to 28 Aug 19 46
 and that I last saw her alive on 27 Aug 46 19 46

Immediate cause of death

Diabetes Mellitus

DURATION

10-12 yrs.

Due to

Coronary Occlusion

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____

Injured at work? _____

23. SIGNATURE Andrew E. Name M.D. or otherAddress Oakland, Md. Date signed 8/30/46

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-2

CERTIFICATE OF DEATH

08083

Reg. Dist. No. 172

1. PLACE OF DEATH:

County **Garrett**
City or town **Rural- Deer Park**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6mi. North- Sand Flat Section

How long in hospital or institution?

3. (a) FULL NAME

Baby Boy O'Brien

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) **August 5, 1946**

8. AGE:

Years

Months

Days

It less than one day

- - - - - hrs. 10 min.9. Birthplace **Rural-Deer Park, Md.**

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name **Joseph Henry O'Brien**13. Birthplace **Swanton, Md.**14. Maiden name **Celia Kathleen Tichinell**15. Birthplace **Bloomington, Md.**16. Informant **Mrs. Celia O'Brien**Address **Deer Park, Md. R#2**17. Burial Date thereof **Aug. 5, 1946**

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory **North Glade Cemetery****North Glade, Garrett Co., Md.**

Location

18. Funeral director **Otha F. Sharpless**Address **Blaine, W. Va.**19. **Aug 5 1946** Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Garrett**City or town **Rural- Deer Park**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **6 Miles North- Sand Flat**

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number
None

MEDICAL CERTIFICATION

August 5 46 8:30A

20. DATE OF DEATH 19. at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 5 1946 to **Aug 5 1946**and that I last saw **Aug 5-46** alive on 19.

Immediate cause of death

Premature separation of PlacentaDue to **Bleed**Due to **5 1/2 months Pregnancy**

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Ralph Culandella M.D.**Address **Kitzmiller, Md.** Date signed **Aug 5-46**

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BUREAU VLS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1319

CERTIFICATE OF DEATH

08084

Reg. Dist. No. 172

1. PLACE OF DEATH County <u>Garrett</u> City or town <u>Rural- Swanton</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>23yrs.</u> Hospital, institution, or street address where death occurred: <u>Swanton, Road</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Garrett</u> City or town <u>Rural- Swanton</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2. (a) If veteran, name war _____			
3. (a) FULL NAME <u>Lena Ellen Otto</u>				3. (b) Social Security Number <u>NONE</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>William Lewis Otto</u>		8. AGE: Years <u>49</u> Months <u>11</u> Days <u>2</u> If less than one day _____ hrs. _____ min.		2D. DATE OF DEATH <u>August 15</u> 19 <u>46</u> at <u>4:45 P.</u>		21. CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan. 1944 to Aug 13 1946</u> and that I last saw <u>her</u> alive on <u>Aug 15 1946</u>	
7. Birth date of deceased (mo., day, yr.) <u>Sept. 13, 1896</u>		8. (c) If alive, give age <u>50</u> years		Immediate cause of death <u>Acute Myocarditis</u>		DURATION <u>1 week</u>	
9. Birthplace <u>Wewternport, Alleg. Co., Md.</u> (Town, county, and state)				Due to <u>Cardio-renal Disease</u>		Due to <u>with Diph.</u>	
10. Usual occupation <u>Housework</u>				Other conditions _____		(Include pregnancy within 3 months of death)	
11. Industry or business <u>Own Home</u>				Major findings of operations _____		Date of op. _____	
12. Name <u>James Simeon Grove</u>		13. Birthplace <u>Westernport, Md.</u>		Autopsy results _____		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
14. Maiden name <u>Fannie Duckworth</u>		15. Birthplace <u>Westernport, Md.</u>		22. VIOLENCE: If death was due to external causes, fill in the following:		Accident, suicide, or homicide _____ Date of _____	
16. Informant <u>William L. Otto</u>		17. Burial <u>North Glade Cemetery</u> (Burial, cremation, or removal. Which?) _____ Cemetery or crematory _____ <u>3mi. N. Swanton, Md.</u> Location <u>Otha F. Sharpless</u> <u>Braine, W. Va.</u>		Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____		Injured at home, farm, industry, public place (where?) _____	
18. Funeral director _____		19. Date rec'd by registrar <u>8/17</u> 19 <u>46</u>		23. SIGNATURE <u>Reft Calumkin</u>		M. D. or other _____	
Address _____		Registrar _____		Address _____		Date signed <u>Aug 16-46</u>	

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BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 08085 161

1. PLACE OF DEATH: Gumville
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....MD..... County.....Gumville
 City or town.....Near Friendsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME John Henry Sines 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) June 22 - 1876 B. (c) If alive, give age..... years

8. AGE: Years 70 Months 2 Days 6 If less than one day..... hrs. min.

9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....Solomon Sines

13. Birthplace.....MD

14. Maiden name.....Mary Richard

15. Birthplace.....MD

16. Informant.....Kathryn Fike

Address.....Oakland MD

17. (Burial, cremation, or removal, Which?) Date thereof.....Aug-30-46
 (month) (day) (year)

Cemetery or crematory.....Land Spring

Location.....Near Friendsville

18. Funeral director.....J. H. Savage

Address.....Friendsville MD

19. Aug 30 19 46 Kathryn Fike
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1946 at 11:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from examined after death 19.....
 and that I last saw him..... alive on..... 19.....

Immediate cause of death.....Coronary Occlusion

Due to.....Arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....P. J. Humphrey Deputy Med. Officer

Address.....Danland MD Date signed.....8/28/46

STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

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SEP 4 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH:

County Garett
 City or town Rural Near Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 Years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Garett
 City or town Rural Near Grantsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Floyd Alvin Swager

3. (b) Social Security Number

Caper F. Swager 218-03-7941

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced
Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 1 1882 6.(c) If alive, give age _____ years

8. AGE: Years 64 Months - Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Rural Near Grantsville Md
 (Town, county, and state)

10. Usual occupation Timber Worker

11. Industry or business

FATHER 12. Name Isaac Swager
 13. Birthplace R.D.2 Grantsville Md

MOTHER 14. Maiden name Virginia Layman
 15. Birthplace Garett Co Md

16. Informant Hubert Swager
 Address Grantsville Md

17. Burial 8.18-1946
 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory Grantsville

Location Grantsville Md

18. Funeral director Mrs. Winterberg
 Address Grantsville Md

Aug 17 1946 19. Ethel Broadwater
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 19 46, at 3.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 19 46 to Aug 16 19 46 and that I last saw him alive on Aug 15 19 46

Immediate cause of death

Chronic myocarditis

DURATION

unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Alexandra Soloshv
Salisbury Pa M. D. or other
 Address Date signed 8/17/46

RECEIVED
AUG 20 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
 City or town Rural Steyer
 (If outside city or town limits, write RURAL and give nearest town)
17 yrs.
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland. County Garrett
 City or town Rural Steyer
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1 Ml. West Steyer, Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war -----

3.(a) FULL NAME

William J. White

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Sallie Mae Smith White
 6.(c) If alive, give age 40 years
 7. Birth date of deceased (mo., day, yr.) November 24, 1876
 8. AGE: Years 69 Months 9 Days 6 It less than one day
 ----- hrs. ----- min.

9. Birthplace Garrett Co., Md.
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Own Farm
 12. Name J. Murray White
 13. Birthplace Garrett Co., Md.
 14. Maiden name Eliza Jane Moon
 15. Birthplace Garrett Co., Md.

16. Informant Mrs. William J. White
 Address Steyer, Md.

17. Burial Sept. 2, 1946
 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Oak Grove Cemetery
 Location 2 mi. N. Gorman, Md.
 18. Funeral director Herbert P. Reighton
 Address Oakland, Md.

19. Sept 2, 1946 Registrar Julia Rowan
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1946 at 1:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15th, 1946 to 30th, 1946 and that I last saw him Aug 25th alive on 1946
 Immediate cause of death Heart failure

Due to Arteriosclerosis
 Due to -----
 Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----
 Date of op. -----

Autopsy results -----
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide ----- Date of -----
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) -----
 Means of injury ----- Injured at work? -----

23. SIGNATURE W. E. Dintwiler M. D. or other
 Address Gorman, W. Va. Date signed Sept 4, 1946

Handwritten notes:
1. Smith
2. St. Louis
3. Washington
4. New York
5. Chicago
6. Boston
7. Philadelphia
8. San Francisco
9. Los Angeles
10. San Diego
11. Dallas
12. Houston
13. Portland
14. Seattle
15. Denver
16. Salt Lake City
17. Sacramento
18. San Jose
19. Fresno
20. Bakersfield
21. Modesto
22. Merced
23. Stockton
24. Yuba City
25. Bay City
26. Midland
27. Amarillo
28. Lubbock
29. Dalhart
30. Big Lake
31. Clovis
32. Hobbs
33. Pecos
34. Lordsburg
35. Lordsburg
36. Lordsburg
37. Lordsburg
38. Lordsburg
39. Lordsburg
40. Lordsburg

REL
SEP 9 1947
BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

08088

Reg. Dist. No. 162

1. PLACE OF DEATH

County GARRETT
 City or town SWANTON (RURAL)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr.
 Hospital, institution, or street address where death occurred: _____
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETT
 City or town RURAL
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. SWANTON
 (If rural, give LOCATION)
 2(a) If veteran, name war NO

3. (a) FULL NAME

MR. JESSE-WILT

3. (b) Social Security Number

NONE

4. Sex

M

5. Color of race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Rachel Wilt

7. Birth date of deceased (mo., day, yr.)

not known

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

78

.....hrs.min.

9. Birthplace

unknown

(Town, county, and state)

10. Usual occupation

Farmel (Retired)

11. Industry or business

FARM

FATHER

12. Name

George Wilt

13. Birthplace

unknown

MOTHER

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Dewey Wilt

Address

Sandpatch Penna

17.

(Burial, cremation, or removal, which?)

Date thereof

AUG 9-1946

Cemetery or crematory

Billings Md Cemetery

Location

St. Stephens Thomas

18. Funeral director

Schubert Penna

Address

Aug 7 46 Ethel Broadwater

19.

(Date rec'd by registrar)

19

46

Ethel Broadwater

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 7 1946 at 2:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1945 to Aug 7 46and that I last saw him alive on July 23 1946

Immediate cause of death

Chronic Myocarditis

DURATION

Due to

Due to

Other conditions

Cerebral thrombosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. Davis M.D.

M. D. or other

Address

Quantico Va

Date signed

Aug 7 46

RECEIVED
AUG 9 1946
BUREAU 78